DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
DIVISION OF LONG-TERM CARE

INFORMED CONSENT AND RELEASE OF INFORMATION FOR PARTICIPATION IN VIRGINIA'S MONEY FOLLOWS THE PERSON PROGRAM (MFP)

Completion of this form and participation in Virginia's Money Follows the Person (MFP) Program is voluntary. I am not required to complete this form or participate in this program; however, if I choose not to complete this form, I am ineligible for participation in the MFP Program.

Whatever decision I make, I can transition to the community, and will continue to be eligible for Medicaid, and for home and community-based services.

Participant Name: _____

Current Institutional Residence: _____

Medicaid Number: ☐☐☐-☐☐☐☐☐☐-☐☐-☐

I, _____,
(Participant's Name) have been informed, allowed to ask questions, and understand that:

☐ My participation in the MFP Program is voluntary.

☐ CMS gave a demonstration award to the Virginia Department of Medical Assistance Services (DMAS) to implement the MFP Program in Virginia. The MFP Program is sponsored by the federal Centers for Medicare and Medicaid Services (CMS) and supports states to strengthen and improve long-term support systems, and assists with transitioning individuals from institutions.

☐ CMS has contracted with Mathematica Policy Research to evaluate the MFP Program nationwide. With my permission, certain information about me will be shared with CMS and with Mathematica Policy Research in order to meet the legal requirements to evaluate the MFP Program.

☐ If I decide not to participate in the MFP Program, I will continue to be eligible for Medicaid home and community-based services.

☐ Upon completion of my one year enrollment in MFP, I will automatically continue to be enrolled in a Medicaid Waiver or Program of All Inclusive Care for the Elderly (PACE) as long as I continue to meet the eligibility criteria for the Medicaid Waiver or PACE.

BENEFITS OF MFP PROGRAM

Potential benefits from my participation in the MFP Program include the following:

☐ An Individual to assist with my transition from the institution to live successfully in the community.

☐ Access to 2-1-1, 24 hours, seven days per week for assistance in obtaining essential services.

☐ Access to Environmental Modifications and Assistive Technology.

☐ Continuity of WAIVER services through the Medicaid home and community-based program, if I continue to meet Medicaid eligibility at the end of my one year

POTENTIAL RISKS

☐ There is a chance (risk) that my confidential information could be released to an organization that is not authorized to see it. The risk of this unauthorized release is very low because procedures are in place to protect my information and limit its release to other parties (as described below.) This risk exists even if I do not participate in the MFP Program.

PARTICIPATION IN EVALUATING THE MFP PROGRAM

☐ I understand that information about my participation in the MFP Program will be provided to CMS and to Mathematica Policy Research, the evaluation contractor hired by CMS.

☐ I may be asked to voluntarily respond to surveys, take part in visits to my home or otherwise communicate with DMAS staff or its designated agent for the MFP Program.

PRIVACY

☐ I have been informed that the information provided by DMAS to CMS and Mathematica Policy Research is confidential and will be protected under the Health Insurance Portability and Accountability Act (HIPAA). I know that I may receive a copy of the DMAS HIPAA Notice of Privacy Practices and procedures at my request. The Notice of Privacy Practices can be found on the DMAS website. The website link is:
http://www.dmas.virginia.gov/Content_atchs/atchs/privacy-note.pdf

CONSENT TO RELEASE INFORMATION FOR MFP PROGRAM PROMOTION

(This is voluntary, and does not affect my participation in the MFP program)

I hereby authorize the use or disclosure of my/our name(s), and photograph as a participant in the Money Follows the Person Program by the Department of Medical Assistance Service (DMAS) for publicity purposes. I understand that this authorization is voluntary and will have no affect on my eligibility or status. I also understand that the information released may include my first and last name, image and details about my circumstances, and participation with the MFP program and the released information will no longer be protected by the federal privacy regulations.

The purpose of the release of my name to DMAS is so that DMAS may contact me to ask questions about my experience with MFP. By agreeing to allow DMAS to contact me, I am voluntarily participating in the promotion of the MFP program by the Department of Medical Assistance Services (DMAS) Division of Long Term Care. My participation will be assisting the MFP program with highlighting my experience with the MFP program through the promotion of my family's personal story and images.

☐ I understand that this authorization will have no expiration date.

☐ I understand that I may revoke this authorization at any time by notifying the DMAS, Division of Long Term Care in writing, but if I do,the revocation will not have any effect on any actions the providing organization took before it received the revocation.

WITHDRAWAL FROM THE MFP

☐ I know that my participation in the MFP Program is voluntary and if I enroll in the MFP Program and change my mind and no longer wish to be in the MFP Program that I may withdraw at any time by completing a withdrawal form. I can get the form from my Transition Coordinator, Support Coordinator/Case Manager, or staff from DMAS.

COMPLAINTS

☐ **About my health and safety**: I understand that if I have a complaint or concern that affects my health, safety or well-being and is an urgent situation, I can call:

- 9-1-1 for life-threatening emergencies.
- 2-1-1 for assistance with emergency backup of essential services.
- 1-888-832-3858 to report allegations of adult abuse, neglect or exploitation.
- 1-800-552-7096 to report allegations of child abuse or neglect.

☐ I understand that my provider is required by law to report critical incidents (suspected abuse, neglect and exploitation) to appropriate entities, including licensing authorities.

About my participation in the MFP

☐ I understand that if I have any concerns about my participation in the MFP Program I can contact DMAS staff at:

Department of Medical Assistance Services
Division of Long-Term Care Services
Money Follows the Person Program
600 East Broad Street, 10th Floor
Richmond, Virginia 23219
Phone: (804) 225.3007
Fax: (804) 452.5468
mfp@dmas.virginia.gov

☐ I understand that I have certain rights to file a grievance or appeal a decision as an individual using Medicaid waiver services. My Transition Coordinator or Support Coordinator/Case Manager has provided me with information regarding my rights as an individual enrolled in MFP using Medicaid waiver services. Information regarding the DMAS appeal process can be found on the DMAS website. The website link is:
http://www.dmas.virginia.gov/content_pgs/appeal-home.aspx

CONSENT

☐ I understand that I will be given a signed copy of this consent form to keep. If I have questions about the MFP Program that cannot be answered by my Transition Coordinator or Support Coordinator/Case Manager, or I may call DMAS at (804) 225-3007 or email MFP@dmas.virginia.gov.

By signing this Informed Consent, I am agreeing to participate in the MFP Program and to accept all conditions for participation.

SIGNATURE – Participant Date Signed

Address (Street, City)

Address (State, Zip Code)

Telephone Number (including area code)

SIGNATURE – Witness (if applicable) Date Signed
A witness may indicate that a participant agreed by making a mark above.

SIGNATURE – Legal Guardian (if applicable) Date Signed

Address (Street, City)

Address (State, Zip Code)

Telephone Number (including area code)

TRANSITION COORDINATOR or SUPPORT COORDINATOR/CASE MANAGER ACKNOWLEDGEMENT

I have provided/will provide a copy of the informed consent form to _____ (Participant Name), and addressed their questions.

SIGNATURE – (Transition Coordinator or Support Coordinator/Case Manager) Date Signed

Printed Name (Transition Coordinator or Support Coordinator/Case Manager) and Agency Name

Telephone Number (including area code) Email Address

DMAS must receive a copy of this form. Copies should be forwarded to DMAS via:

secure email: MFP@dmas.virginia.gov
or
Faxed to (804) 452.5468

OPTION TO VOLUNTARILY DECLINE PARTICIPATION

☐ I was offered the opportunity to participate in the MFP Program and have chosen to decline. I understand that this will not affect my eligibility for Medicaid or home and community-based services.

SIGNATURE – Participant Date Signed

Address (Street, City)

Address (State, Zip Code)

Telephone Number (including area code)

SIGNATURE – Witness (if applicable) Date Signed
A witness may indicate that a participant agreed by making a mark above.

SIGNATURE – Legal Guardian (if applicable) Date Signed

Address (Street, City)

Address (State, Zip Code)

Telephone Number (including area code)

DMAS must receive a copy of this form. Copies should be forwarded to DMAS via:
secure email: MFP@dmas.virginia.gov
or
Faxed to (804) 452.5468

INFORMED CONSENT INSTRUCTIONS

1) Enter Participant's Full Legal Name in blank.

2) Enter the name of the Participant's Current Institutional Residence.

3) Example: *ABC Nursing Facility or Training Center*

4) Enter the Participant's 12-digit Medicaid Number

5) Check each box as the information is reviewed with the participant.

6) Complete the Consent Section with the Participant's Information.

7) If the Participant is willing to have their story released or shared for promotion of the MFP Program have them complete and initial the CONSENT TO RELEASE INFORMATION section of this form.

8) If the Participant is unable to sign, but can make their legal mark, then a witness needs to sign and date that they verified Participant's legal mark.

9) Complete the Consent Section with the Legal Guardian's Information, if applicable.

10) Complete the Transition Coordinator/Support Coordinator/Case Manager, Section with the appropriate information.

11) If applicable, complete the Option to Formally Decline Participation Section. This section is only completed if the Participant is opting ***NOT*** to participate in the MFP program, after being provided information about the program.

12) Original forms must be maintained in the Participant's MFP record by the Transition Coordinator or Support Coordinator/Case Manager for a period of not less than five years from the date of service, and submitted to DMAS via secure email MFP@dmas.virginia.gov or FAX at 804-452.5468